Utah DHS-DSPD
1/00

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

SERVICE PLAN

Form 1-15

10

TYPE OF PLAN: ❑ INDIVIDUAL ❑ FAMILY ❑ FAMILY-CENTERED
SOURCE OF FUNDING: ❑ DD/MR WAIVER ❑ BRAIN INJURY WAIVER ❑ NON-WAIVER

Plan's Effective Date:___/___/___ MM DD YY	Plan's End Date:___/___/___ MM DD YY

Name	Address	Phone Number
Person:		( )-
Support Coordinator:		( )-

Support Coordination (formerly Case Management) serves the purpose of: (a) establishing and maintaining the individual in the support system and if applicable in the Home and Community-Based Waiver in accordance with program requirements and the individual's assessed support needs and (b) coordinating the delivery of quality waiver and non-waiver services.

Outcome: Please check all that apply:
❑ all outcomes listed below
❑ establish Medicaid financial and categorical eligibility,
❑ gain access to waiver supports, state plan services, medical, social, and educational assessments and services, and any other services, regardless of the funding source,
❑ develop a personal budget based on the individual support plan,
❑ identify the supports necessary to insure the individual's health and safety,
❑ write and update personal social history,
❑ write, coordinate, integrate, and assure the implementation of the individual's support plan, and
❑ ensure a person-centered plan is written and implemented,
❑ provide ongoing monitoring to assure the provision and quality of the supports identified in the individual's plan,
❑ provide an initial assessment and ongoing reassessment of the individual's level of care determination,
❑ review the individual's support plan as needed/at least annually,
❑ instruct the individual/legal representative/family how to independently obtain access to services and supports, regardless of funding source, and
❑ provide discharge planning services up to 30 days immediately prior to the date an individual living in an ICF/MR is admitted to the waiver.
❑ other (please specify):_____

Expected Start Date: ___/___/___ MM DD YY	Intensity:	Name/Title of Provider: Qualified Mental Retardation Professional with State Division
Amount/Frequency:		
Duration:		

Medical

Outcome: Please check all that apply:
❑ ensure person has the best possible health
❑ other (please specify)_____

Expected Start Date: ___/___/___ MM DD YY	Intensity:	Name/Title of Provider:
Amount/Frequency:		
Duration:		

Dental

Outcome: Please check all that apply:
❑ ensure person receives preventative and necessary dental care and check ups.
❑ other (please specify)_____
_____
___

Expected Start Date: ___/___/___ MM DD YY	Intensity:	Name/Title of Provider:
Amount/Frequency:		
Duration:		

Day Support (site and non-site based day support or senior supports)

Outcome: Please check all that apply:
❑ provide structure, supervision, and meaningful activity for person with brain injury
❑ facilitate independence and community inclusion and contribution, maintain the person's physical and mental skills, provide instruction in skills a person wishes to acquire, retain, or improve
❑ provide support for older adult or person who has needs closely resembling an older adult to facilitate inclusion and prevent social isolation
❑ other (please specify)_____
_____
___

Expected Start Date: ___/___/___ MM DD YY	Intensity:	Name/Title of Provider:
Amount/Frequency:		
Duration:		

Community Living Support (companion services, supported marriage for married couples, supported living, supervised living, host or professional parent home, etc.)

Outcome: Please check all that apply:
❑ facilitate independence and promote community integration by assisting the person to gain or maintain skills necessary to live alone or with roommates as independently as possible in the type of community-based housing arrangement the Person chooses.
❑ other (please specify)_____
_____
___

Expected Start Date: ___/___/___ MM DD YY	Intensity:	Name/Title of Provider:
Amount/Frequency:		
Duration:		

Mental Health

Outcome: Please check all that apply:
❑ Maintain or improve the person's mental health and overall functioning.
❑ other (please specify)_____
_____
___

Expected Start Date: ___/___/___ MM DD YY	Intensity:	Name/Title of Provider:
Amount/Frequency:		
Duration:		

Transportation (bus pass, taxi or day or community living support provider transportation)

Outcome: Please check all that apply:
❑ allow the person to access other supports necessary to live an inclusive community life
❑ other (please specify)_____
_____
___

Expected Start Date: ___/___/___ MM DD YY	Intensity:	Name/Title of Provider:
Amount/Frequency:		
Duration:		

Personal Assistance

Outcome: Please check all that apply:
❑ Provide personal care and non-medical supportive services specific to the person's needs
❑ other (please specify)_____
_____
___

Expected Start Date: ___/___/___ MM DD YY	Intensity:	Name/Title of Provider:
Amount/Frequency:		
Duration:		

Personal Emergency Response System

Outcome: Please check all that apply:
❑ Allow the person who has the skills to live independently or with minimal support to summon assistance in an emergency by use of an electronic device. Payment shall include the rental, purchase, installation, removal, replacement and or repair of the system.
❑ other (please specify)_____
_____
___

Expected Start Date: MM DD YY ___/___/___	Intensity:	Name/Title of Provider:
Amount/Frequency:		
Duration:		

Environmental Accessibility Adaptations (ramps, lifts/elevators, modifications/additions of bathroom facilities, floor urinal and bidet adaptations and plumbing modifications, turnaround space adaptations, widening of doorways/hallways, specialized accessibility/safety adaptations/additions, vehicle adaptations, trained and certified canine assistance).

Outcome: Please check all that apply:
❑ enable the person to effectively function in the home's physical environment by adapting the home with equipment and/or physical improvement to the home or vehicle necessary to assure the health, welfare or safety of the person.
❑ improve the person's level of independent functioning.
❑ other (please specify)_____
_____
___

Expected Start Date: MM DD YY ___/___/___	Intensity:	Name/Title of Provider:
Amount/Frequency:		
Duration:		

Chore and Homemaker (heavy household chores, snow removal, lawn care, carpet care, cleaning, and general household duties).

Outcome:
❑ maintain a clean, sanitary and safe living environment for the person
❑ other (please specify)_____
_____
___

Expected Start Date: MM DD YY ___/___/___	Intensity:	Name/Title of Provider:
Amount/Frequency:		
Duration:		

Work Support (supported employment)

Outcome: Please check all that apply:
❑ assist the person find, keep, or change, employment or to advance in employment
❑ other (please specify)_____
_____
___

Expected Start Date: ___/___/___ MM DD YY	Intensity:	Name/Title of Provider:
Amount/Frequency:		
Duration:		

Latch-Key Support (before and after school or work day child care).

Outcome: Please check all that apply:
❑ provide supervision for child who is not receiving community living support and whose parents are working
❑ other (please specify)_____
_____
___

Expected Start Date: ___/___/___ MM DD YY	Intensity:	Name/Title of Provider:
Amount/Frequency:		
Duration:		

Respite Care (day and overnight supports).

Outcome: Please check all that apply:
❑ provide supervision and/or relief, on a short-term basis for those individuals who normally provide care in a home setting for person unable to care for self
❑ other (please specify)_____
_____
___

Expected Start Date: ___/___/___ MM DD YY	Intensity:	Name/Title of Provider:
Amount/Frequency:		
Duration:		

Educational Supports (specialized education, personal tutoring, personal instructions and registration fees for generic education and related services).

Outcome: Please check all that apply:
❑ provide individualized educational opportunities
❑ other (please specify)_____
_____
___

Expected Start Date: ___/___/___ MM DD YY	Intensity:	Name/Title of Provider:
Amount/Frequency:		
Duration:		

Family Assistance and Support (in or out of home assistance to keep family together and allow for parents to care for a child with a disability at home).

Outcome: Please check all that apply:
❑ provide information and training about treatment, rehabilitative regimens and use of equipment necessary to safely maintain the person with a disability at home
❑ allow the child to remain and be supported in the family home
❑ provide leisure time activity and community inclusion for the child
❑ provide training, instruction, supervision to the family, caregiver, or child in all areas of daily living
❑ other (please specify)_____
_____
___

Expected Start Date: ___/___/___ MM DD YY	Intensity:	Name/Title of Provider:
Amount/Frequency:		
Duration:		

Specialized Supports (chiropractic therapy, acupuncture, massage therapy, communication support, counseling for siblings).

Outcome: Please check all that apply:
❑ provide treatment, training, consultation, or other unique services necessary to achieve improvement in physical/mental health
❑ provide training, consultation or treatment to facilitate communication or use of alternative communication strategies
❑ provide training, instruction, and counseling to siblings of a person with disability to improve or maintain the home unit and facilitate positive relations and family dynamic
❑ other (please specify)_____
_____
___

Expected Start Date: ___/___/___ MM DD YY	Intensity:	Name/Title of Provider:
Amount/Frequency:		
Duration:		

Brain Injury Homemaker Service (household activities).

Outcome: Please check all that apply:
❑ provide meal preparation and routine household care for the person
❑ other (please specify)_____
_____
___

Expected Start Date: MM DD YY ___/___/___	Intensity:	Name/Title of Provider:
Amount/Frequency:		
Duration:		

Brain Injury Companion Service (supervision and socialization services).

Outcome: Please check all that apply:
❑ provide a companion to assist the person in connecting with the community and to avoid isolation
❑ provide assistance with meal preparation, laundry, shopping, etc.
❑ other (please specify)_____
_____
___

Expected Start Date: MM DD YY ___/___/___	Intensity:	Name/Title of Provider:
Amount/Frequency:		
Duration:		

Brain Injury Counseling (conflict resolution/counseling for person and person's family).

Outcome: Please check all that apply:
❑ provide treatment, training, consultation, or other unique services necessary to achieve improvement in person's mental health
❑ provide training, consultation or treatment to facilitate communication of problem areas
❑ provide training, instruction, and counseling to improve or maintain the home unit and facilitate positive relations and family dynamic
❑ other (please specify)_____
_____
___

Expected Start Date: MM DD YY ___/___/___	Intensity:	Name/Title of Provider:
Amount/Frequency:		
Duration:		

non-waiver Wellness Monitoring (evaluation of the general health and wellness of a person to access the medical health services being provided and review medical history for planning completed by a registered nurse).

Outcome: Please check all that apply:
❑ promote the person's health status and prevent unnecessary physical and functional deterioration
❑ other (please specify)_____
_____
___

Expected Start Date: ___/___/___ MM DD YY	Intensity:	Name/Title of Provider:
Amount/Frequency:		
Duration:		

non-waiver Guardianship Supports (acquisition of and ongoing support for obtaining/maintaining guardianship, or support for challenge to guardianship).

Outcome: Please check all that apply:
❑ assure the person's legal rights are appropriately promoted and protected
❑ other (please specify)_____
_____
___

Expected Start Date: ___/___/___ MM DD YY	Intensity:	Name/Title of Provider:
Amount/Frequency:		
Duration:		

non-waiver Supplemental Child Care (childcare costs associated with a child 12 years old or younger with a disability that includes training or extra compensation for the child care provider).

Outcome: Please check all that apply:
❑ promote care in a natural family like setting so that parents may work or attend school
❑ other (please specify)_____
_____
___

Expected Start Date: ___/___/___ MM DD YY	Intensity:	Name/Title of Provider:
Amount/Frequency:		
Duration:		

non-waiver Housing Access Coordination (information and assistance in identifying housing options, assistance with identification of accessibility issues, home maintenance and repair planning, facilitation of financial resources for home purchase).

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Outcome: Please check all that apply:
❑ assist the person to acquire appropriate, affordable, long-term, personal housing in the community
❑ assist the person to purchase his/her own home
❑ other (please specify)_____
_____
___

Expected Start Date: ___/___/___ MM DD YY	Intensity:	Name/Title of Provider:
Amount/Frequency:		
Duration:		

Assessment

Outcome: Please check all that apply:
❑ other (please specify)_____
_____
___

Expected Start Date: ___/___/___ MM DD YY	Intensity:	Name/Title of Provider:
Amount/Frequency:		
Duration:		

Emergency Plan

Outcome: Please check all that apply:
❑ other (please specify)_____
_____
___

Expected Start Date: ___/___/___ MM DD YY	Intensity:	Name/Title of Provider:
Amount/Frequency:		
Duration:		

Social/Recreation

Outcome: Please check all that apply:
❑ other (please specify)_____
_____
___

Expected Start Date: ___/___/___ MM DD YY	Intensity:	Name/Title of Provider:
Amount/Frequency:		
Duration:		

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Amount/Frequency:
Duration:

My support coordinator has presented me with all available service and support options, as well as all available providers of these services and supports. The providers of services and supports listed on this plan represent my choice. My support coordinator has also informed me of my rights according to Policy 1-1, Individual Rights, and my right to a hearing according to Policy 1-5, Notice and Hearings for Agency Actions. I understand that if I disagree with the above choice of providers that I have a right to a hearing within the time frames specified on form 490S, Your Hearing Rights.

Signatures:

Person:_____ Date:_____

Support Coordinator:_____ Date:_____

Person's Legal Representative:_____ Date:_____

A. NON-WAIVERED SERVICE NEEDS TO BE CONSIDERED: ASSESSMENT; COUNSELING/THERAPY; EMERGENCY PLAN; INCOME SOURCE; MEDICAL; MEDICAL SERVICES INSURANCE (MEDICAL CARD); SOCIAL/RECREATION.

Additional components to allow use of this plan as a Family-Centered Plan.

- ❑ assessment of persons ability
- ❑ assessment of concerns and priorities of person and family
- ❑ action steps
- ❑ family responsibilities
- ❑ team member time lines and expectations
- ❑ dated signatures from all team members